

# Clear Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**

Jun/24/2009

DATE OF AMENDED REVIEW: JULY 1, 2009

**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient lumbar discogram with post CT scan

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

M.D., Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines

Electrodiagnostic Studies, 09/14/06

MRI Lumbar Spine, 03/14/07

Office notes, Dr. 10/02/08, 11/13/08, 02/12/09

MRI Lumbar Spine, 10/09/08

Request, 02/17/09

Pre-Procedure Psychological Evaluation, 03/02/09

Request, Dr., 04/20/09

Review, Provider Unknown, 04/24/09

Review, 05/27/09

Requests for lumbar discogram, 05/18/09, 06/05/09

Prospective Review, 06/07/09

Patient Face Sheet, 02/17/09

Pre-authorization Fax, 03/16/09, 04/24/09

Notes from Risk Management, 04/28/09, 06/03/09

Faxes, 05/27/09

**PATIENT CLINICAL HISTORY SUMMARY**

This male injured his low back while moving a gallon of paint on xx-xx-xx. Electrodiagnostic studies on 09/14/06 demonstrated lumbar radiculopathy involving the L5 and S1 nerve roots bilaterally, which appeared to be most significant at the left L5 and S1 nerve root levels. Lumbar radiculopathy was indicated by increased chronic reinnervation potential activity recorded in L5 and S1 innervated paraspinals and distal musculature within the bilateral lower extremities. He had significant acute denervation potential activity was also observed

within the left L5 and S1 myotomes. There was no electrophysiological evidence of distal mononeuropathy was recorded in these electrodiagnostic studies of the lower extremities.

At some time the claimant underwent a discectomy from L3-5. A lumbar MRI on 03/14/07 revealed a previous surgery of the lumbar spine with post surgical changes at L3-4, L4-5 and behind the L5 vertebral centrum. There was what may be either disc material or scar is seen along the margin of the disc as well as the peridural space on the left side at L3-4, L4-5, and posteriorly behind the L5 centrum. Central stenosis was not observed. The changes within the disc at the L3-4 and L4-5 were suspected to represent changes related to microdiscectomy. Dr. saw the claimant on 10/02/08 for worsening back pain radiating down into the left leg with numbness and weakness and progressive weakness and difficulty walking. Coughing and sneezing aggravated it. He also reported electrical shock and spasm in the spine. The examination showed straight leg raise at 90 degrees on the right and 45 degrees on the left, decreased strength in the left leg about 4+/5 in the iliopsoas and quadriceps. There was decreased sensory in the L4-5 distribution, 2+ reflexes at the knees and 1+ at the ankles indicating an L5-S1 disc. He had an antalgic gait. Lumbar radiculopathy and a lumbar disc at L3-4 were diagnosed. A lumbar MRI, EMG/NCV studies, referral back to Dr. for lumbar fusion, Soma, Celebrex, Talwin and off work were recommended. A lumbar MRI on 10/09/08 showed laminectomies L3-4 and L4-5. There were disc bulges at these levels with neural foraminal narrowing greater on the left at both of these levels. At the 11/13/08 followup decreased lumbar motion, straight leg raise at 70 degrees on the right and 40 degrees on the left, reflexes of 3+ at the knees and 1+ at the ankles were noted. The rest of the examination was unchanged. Dr. re-evaluated the claimant on 02/12/09 stating that coughing, sneezing and bowel movements increased his pain. Straight leg raise at about 60 degrees on the right and 30 degrees on the left was noted. The examination was otherwise unchanged. A psychological evaluation on 03/20/09 showed no contraindications to the lumbar discogram. The request was denied on 2 reviews and is currently under dispute. According to Dr. IRO response dated 06/07/09 the claimant had treated with physical therapy modalities, bilateral facet injections, micro-discectomies, chemical rhizotomies at L3-4 and L4-5 x 2 in 2006 and had recently had 20 sessions of pain management.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The requested outpatient lumbar discogram with post CT scan is not medically necessary based on review of this medical record. This claimant has undergone lumbar disc surgery in the past and has studies documenting either scar tissue and/or recurrent disc herniation along with EMG studies documenting radicular abnormalities. There are positive physical findings documenting weakness and this patient continues to have limitations in function. There has never been an MRI with contrast performed and so it is very difficult to determine from these medical records whether or not this is postoperative scar or recurrent disc, however the patient does have neurologic deficit consistent with his prior surgery and MRI findings. A discogram has been requested assumedly to determine whether or not this claimant would benefit from fusion surgery. Lumbar discogram is not medically necessary to determine whether or not this claimant in fact needs disc surgery. There are no good studies documenting the use of discogram as a determination as to whether or not people improve or do not improve with fusion surgery. Therefore, the requested discogram is not medically necessary. Discography is not recommended in ODG. The reviewer finds that medical necessity does not exist for Outpatient lumbar discogram with post CT scan.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Low Back-Discography)

Discography is Not Recommended in ODG

Patient selection criteria for Discography if provider & payor agree to perform anyway

- o Back pain of at least 3 months duration

- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria
- o Briefed on potential risks and benefits from discography and surgery
- o Single level testing (with control)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

- ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)